



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Beth Ann Applegate, D.C.

**Respondent Name**

Dallas Area Rapid Transit

**MFDR Tracking Number**

M4-17-0879-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

December 1, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Please see the attached DD Report and billing along with the EOB that was sent to us on a POS card paying only part of the charges."

**Amount in Dispute:** \$900.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Per the CMS-1500 as well as the written report for this Designated Doctor Exam, the services being billed (99456-W5,WP) were for Maximum Medical Improvement and Impairment Rating of one body area (with Range of Motion). As such, these services were paid at the correct reimbursement of \$350.00 & \$300.00, respectively, as outlined in the Texas Administrative Code, Rules 134.204(j)(3)(C) and 134.204(j)(4)(C)(ii)(II)(-a-)."

**Response Submitted by:** ESIS

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2016	Designated Doctor Examination	\$900.00	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.250 sets out the fee guidelines for maximum medical improvement evaluations and impairment rating examinations, for dates of service on or after September 1, 2016.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - SR101 – Bill is denied; invalid/missing healthcare provider license number. Please re-submit with appropriate license number for review.
  - 148 – This procedure on this date was previously reviewed.
  - 18 – Duplicate claim/service.

### **Issues**

1. Is Dallas Area Rapid Transit's reason for denial of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

### **Findings**

1. Beth Ann Applegate, D.C. is seeking an additional \$900.00 reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating. On a review analysis dated November 2, 2016, Dallas Area Rapid Transit (DART) denied the disputed services with claim adjustment reason code SR101 – "Bill is denied; invalid/missing healthcare provider license number. Please re-submit with appropriate license number for review."

Review of the submitted information finds that DART did not maintain this denial on subsequent reviews. DART's denial for this reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.250(3), "The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." The submitted documentation supports that Dr. Applegate performed an evaluation of Maximum Medical Improvement. Therefore, the MAR for this examination is \$350.00.

Per 28 Texas Administrative Code §134.250(4), "The following applies for billing and reimbursement of an IR evaluation. ... (C)(ii) The MAR for musculoskeletal body areas shall be as follows. ... (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area." The submitted documentation supports that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the left knee. Therefore, the MAR for this examination is \$300.00.

3. The total MAR for the disputed services is \$650.00. Documentation supports that DART paid \$650.00. No further reimbursement is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

### **Authorized Signature**

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Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	December 22, 2016 Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**